

**OKLAHOMA DEPARTMENT OF CORRECTIONS  
CONTROLLED DRUG PRESCRIPTION FORM**

**Note: All information below must be provided. No alterations on face of prescription can be made.**

**Note: Only one controlled drug per prescription.**

Inmate Name: \_\_\_\_\_

DOC #: \_\_\_\_\_ SSN #: \_\_\_\_\_

Facility: \_\_\_\_\_ Cost Center #: \_\_\_\_\_

Medication: \_\_\_\_\_ Quantity: \_\_\_\_\_

Directions: \_\_\_\_\_

Date Written: \_\_\_\_\_ Start Date: \_\_\_\_\_ Stop Date: \_\_\_\_\_

Signature of Provider: \_\_\_\_\_

DEA #: \_\_\_\_\_

Printed Name: \_\_\_\_\_

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**Please provide the full facility name and street address in the space below.**

Facility: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

**NOTE: When ordering a Schedule II controlled pharmaceutical, the SIGNED ORIGINAL "Schedule II Controlled Prescription Form" must be mailed to:**

**Diamond Pharmacy Services  
Commerce Park  
Attn: Medical Department Supervisor  
645 Kolter Drive  
Indiana, PA 15701**

**IMPORTANT: A COPY OF THIS DOCUMENT MUST BE MAINTAINED ON FILE BY THE CHSA FOR 5 YEARS.**

For Questions Call 1.800.882.6337